0399 The Global Consumer Choice Waiver: Rebalancing the Long-Term Care System

0399.01 OVERVIEW

EFF: 07/2009

One of the most important goals of the Global Consumer Choice Compact Waiver (Global Waiver) is to ensure that every beneficiary receives the appropriate services, at the appropriate time, and in the appropriate and least restrictive setting. To achieve this goal for long-term care (LTC) services, the waiver provides the state with the authority to collapse its existing section 1915 (c) home and community based service waivers (HCBS), which have different eligibility criteria and services, into its newly approved section 1115 (a) Global Waiver. Under the Global Waiver, the scope of services available to a beneficiary is not based solely on a need for institutional care, but is based on a comprehensive assessment that includes, but is not limited to, an evaluation of the medical, social, physical and behavioral health needs of each applicant.

0399.02 Transition to the Global Waiver

EFF: 07/2009

The authority for the State of Rhode Island to provide home and community-based services transitions from the authority found in 1915(c) of the Social Security Act to that found in Section 1115 of the Act on July 1, 2009. The transition in authority allows the State to implement new needs-based levels of care, expand the number of individuals that can access long-term care services, and increase the availability of home and community-based services. On June 1, 2009 letters were sent to all Home and Community-based Waiver participants notifying them of the transition in authority. The agencies with authority to determine access for LTC prior to July 1, 2009, shall retain that authority subsequent to the transition date unless otherwise stated in this rule.

0399.03: ACCESS TO LONG-TERM CARE

EFF: 07/2009

For the purposes of this section, Medicaid funded long-term care is defined as institutional services or home and community-based services and supports. Long-term care services are designed to help people who have disabilities or chronic care needs to optimize their health and retain their independence. Services may be short or long-term and may be provided in a person's home, in the community (for example, shared living or assisted living), or in institutional settings (for example, intermediate care facilities, hospitals, or nursing homes).

0399.04 TYPES OF LONG-TERM CARE

EFF: 07/2009

To achieve the goal of rebalancing the long-term care system, the Global Consumer Choice Compact Waiver allows beneficiaries to obtain the Medicaid services they need in the most appropriate least restrictive setting. The types of long-term care available to beneficiaries are categorized as institutional and home and community.

0399.04.01 Institutional Care

EFF: 07/2009

Beneficiaries that meet the applicable clinical eligibility criteria may access institutional long-term care services in the following facilities:

a) Nursing Facilities (NF). A beneficiary is eligible to access Medicaid-funded care in a nursing facility when it is determined on the basis of a comprehensive assessment, as defined in Sections 0399.05.01.02 and 0399.11, that the beneficiary has the highest level of care needs (See Section 0399.12.01).
b) Intermediate Care Facility for the Mentally Retarded (ICF/MR). A beneficiary qualifies for an ICF/MR level of care if the beneficiary has been determined by the

MHRH to meet the applicable institutional level of care. Rules governing such determinations are located in: "Rules and Regulations Relating to the Definition of Developmentally Disabled Adult and the Determination of Eligibility as a Developmentally Disabled Adult, by MHRH" and may be obtained at http://www.mhrh.ri.gov/ddd/pdf/MHRH_1746.pdf or by contacting the agency.

c) Long-term Acute Care Hospital - Eleanor Slater Hospital (ESH). A beneficiary qualifies for a long-term acute care hospital stay if the beneficiary has been determined to meet an institutional level of care by the MHRH and by the DHS.

Beneficiaries residing in an NF, ICF/MR and ESH are considered to be in an institution for the purposes of determining eligibility. The Medicaid payment for institutional care is reduced by the amount of the beneficiary's income after certain allowable expenses are deducted. Other rules applicable to institutional care and services are located in the Sections of 0378.

0399.04.02 Home and Community Based Long-Term Care

EFF: 07/2009

The Global Waiver authorizes the state to offer an array of home and community-based services to beneficiaries as an alternative to institutionalization. Home and community-based long-term care services and supports (HCB/LTC Services) are in addition to the services otherwise provided under the Medicaid program.

0399.04.02.01 Core and Preventive Types of HCB/LTC Services

EFF: 07/2009

1) Core HCB/LTC services include the following broad categories of services:

- Homemaker
- Environmental Modifications
- Adult Companion Services
- Personal Care Assistance Services

- Special Medical Equipment
- Home Delivered Meals
- Personal Emergency Response
- Licensed Practical Nurse Services (Skilled Nursing)
- Community Transition Services
- Residential Supports
- Participant Directed Goods and Services
- Assisted Living
- Respite
- Day Supports, including Adult Day Services
- Supported Employment
- Shared Living/Supported Living Arrangements
- Private Duty Nursing
- Supports for Consumer Direction
- Case Management
- PACE

Assisted Living, PACE and Shared Living are defined in greater detail in Sections 0399.20.01, 0399.21 and 0399.20.02.

2.) Preventive Services: Persons who are eligible for Community Medical Assistance but who have been determined to meet a preventive level of care, have access to the following services; or other core services that have been identified to help avoid or delay institutional or higher intensity needs:

Homemaker Services
Minor Environmental Modifications
Physical Therapy Evaluation and Services
Respite Services

Section 0399.05 ELIGIBILITY REQUIREMENTS

EFF: 07/2009

To qualify for Medicaid-funded long-term care services under the Global Waiver, a person must meet the general and financial eligibility requirements as well as meet certain clinical eligibility criteria. The general eligibility requirements for Medicaid are

set forth in Sections 0300.25 and 0300.25.20.05 respectively. Income and resource eligibility rules for Medicaid eligible persons who are likely to be residents of an institution (as specified in Section 0399.04.01) for a continuous period and who have a spouse living in the community are found in Sections 0380.40-0380.40.35 and 0392.15.20-0392.15.30. Clinical eligibility is determined by an assessment of a beneficiary's level of care needs. Under the Global waiver, the income and eligibility rules in these Sections will apply to persons who are likely to receive home and community-based core services for a continuous period. That is, persons meeting the highest or high level of care who reside in the community.

In Sections 0380.40-0380.40.35 and 0392.15.20-0392.15.30, all references to institutionalized spouses and continuous periods of institutionalization will include spouses receiving home and community-based services in lieu of institutional services.

0399.05.01 Clinical Eligibility – Scope and Applicability
EFF: 07/2009

The needs-based clinical levels of care **DO NOT** apply to beneficiaries eligible to receive Medicaid-funded long-term care services who were living in institutions on or before June 30, 2009. The institutional level of care criteria will continue to be applied to these beneficiaries until an annual reassessment. If a beneficiary chooses to move to the community, the new needs-based levels of care would apply at the time eligibility is re-determined.

The needs-based levels of care **DO** apply to beneficiaries eligible to receive Medicaid-funded long-term care services who are living in the community on or before June 30, 2009. The new levels of care will apply beginning with the beneficiary's annual re-assessment. If a person met the institutional level of care criteria in the past, he or she will meet either the highest or high level of care in the future, and eligibility for long-term care services will continue without interruption, providing all other general and financial eligibility requirements continue to be met.

The needs-based levels of care will apply to persons seeking, on or after July 1, 2009, Medicaid funded long-term care services provided in a nursing facility or community alternative to that facility.

d) Persons seeking Medicaid-funded long-term care services and supports administered by the Department of Mental Health, Retardation, and Hospitals (MHRH) will continue to meet the clinical eligibility standards in effect – that is, the level of care of intermediate facility for the mentally retarded/developmental disabled (ICFMR/DD) until such time as a needs-based set of criteria are developed in accordance with the terms and conditions established under the waiver. Rules governing such determinations are located in: "Rules and Regulations Relating to the Definition of Developmentally Disabled Adult and the Determination of Eligibility as a Developmentally Disabled Adult, by MHRH" and may be obtained at http://www.mhrh.ri.gov/ddd/pdf/MHRH_1746.pdf or by contacting the agency.

Persons seeking Medicaid-funded long-term care services provided in a long-term care hospital or in a community-based alternative to the hospital will continue to need to meet an institutional level of care. This applies to individuals who would have sought services under the 1915(c) Habilitation Waiver.

Beneficiaries who are not clinically eligible for long-term care may be eligible for a limited range of home and community based services if they meet the criteria to qualify for preventive care (see "preventive need" in Section 0399.12.03). Medicaid beneficiaries who do not meet the long-term care financial eligibility criteria may access preventive home and community-based services that will optimize their health and deter or delay the need for highest or high level of care. The availability of such services shall be limited, depending upon funding.

0399.05.01.02 Needs-based LTC Determinations

EFF: 07/2009

The processes for determining clinical eligibility are based on a comprehensive assessment that includes an evaluation of the medical, social, physical and behavioral health needs of each beneficiary. The assessment shall be tailored to the needs of the beneficiaries services and, as such, may vary from one process to the next. Based on this assessment, the needs of the beneficiary are classified as "highest" or "high" to reflect the scope and intensity of care required and the range of services available. Beneficiaries already eligible for community MA who do not meet the highest or high level of care but are at risk for institutionalization may access certain short-term preventative services. There are two general types of services available to beneficiaries – core and preventive (see description in section 0399.10.20). An individual care plan is then developed that identifies the LTC core and preventive services and settings appropriate to meet the beneficiary's needs within the specified service classification.

The scope of services accessible to a beneficiary varies in accordance with individual needs, preferences, availability, and the parameters established in the Global Waiver and/or federal and state regulations, rules or laws. For example, a beneficiary with the highest need may be able to obtain the full range of services he or she needs at home or in a shared living arrangement, but may choose, instead, to access those services in a skilled nursing facility. Community-based care includes PACE and accessing services through a self-directed model. A beneficiary determined to meet the high need has access to care in the home and community based setting – including PACE -- and self-directed care, but does not have the option of nursing facility care.

0399.05.01.03 LTC Level of Care and Service Option Matrix

EFF: 07/2009

Highest Nursing Home Level of Care	Highest Hospital Level of Care	Highest ICF/MR Level of Care

(Access to Nursing Facilities and all Community-Based Services)	(Access to Hospital, Residential Treatment Centers and all Community-Based Services)	(Access to ICF/MR and all Community Based Services)
High Nursing Home Level of Care (Access to Community-Based Services)	**High Hospital Level of Care** (Access to Community-Based Services)	High **ICFMR Level of Care** (Access to Community-Based Services)
Preventive Nursing Home Level of Care (Access to Preventive Community-Based Services)	**Preventive Hospital Level of Care** (Access to Preventive Community-Based Services)	**Preventive ICFMR Level of Care** (Access to Preventive Community-Based Services)

The scope of services accessible to a beneficiary varies in accordance with individual needs, preferences, availability, cost and the budget neutrality parameters established in the Global Waiver and/or federal and state regulations, rules or laws. For example, a beneficiary with the highest need may be able to obtain the full range of services he or she needs at home or in a shared living arrangement, but may instead choose to access those services in a nursing facility. Community-based care includes PACE and accessing services through a self-directed model. A beneficiary determined to meet the high need has access to care in the home and community based setting – including PACE -- and self-directed care, but does not have the option of nursing facility care.

0399.06 ASSESSMENT AND COORDINATION ORGANIZATION (ACO)

EFF: 07/2009

The Assessment and Coordination Organization (ACO) is a set of four (4) processes established across the health and human service departments that assist applicants/recipients and their families in gaining access to and navigating the LTC system. In this respect, the ACO is not a separate and distinct entity, but a set of interrelated activities from across the departments that serve the goal of rebalancing the long-term care system. The four processes included in the ACO are as follows:

a) Information and Referral. The State provides information and referrals about publicly-funded LTC to individuals and families through a variety of sources across agencies. The ACO is responsible for enhancing and coordinating these resources to ensure that every person seeking Medicaid-funded LTC services has access to the information they need to make reasoned choices about their care. The Department of Human Services shall enter into inter-agency agreements with each entity identified or designated as a primary source of information/referral source for beneficiaries of long-term care.

b) Eligibility Determination. Through the ACO, the Department of Human Services determines financial eligibility for long-term care services provided across agencies. Clinical eligibility is based on a comprehensive assessment of a person's medical, social, physical and behavioral health needs. Responsibilities for clinical eligibility are as follows:

- Clinical eligibility to receive services in a nursing facility or community alternative to that institution will be determined by DHS, utilizing needs-based criteria.

- Clinical eligibility to receive services in a long-term care hospital or community alternative to the institution will be determined by DHS and MHRH utilizing an institutional level of care.

- Clinical eligibility to receive services in an intermediate care facility or community alternative to that institution will be determined by the Department of Mental Health Retardation and Hospitals, using an institutional level of care.

- The entities that conduct the assessments work in coordination with staff of the Medicaid agency, as appropriate, to ensure the eligibility determination process is coordinated and to preserve program integrity.

c) Care Planning. The comprehensive assessment used to determine clinical eligibility and additional information provided by the beneficiary and/or family members is used by the responsible agency to develop an individualized care plan, identifying the scope and amount of services required to meet the beneficiary's needs as well as the full array of service/care setting options. ACO care planning activities include establishing funding levels for the care and/or the development of a budget for self-directed services or the provision of vouchers for the purchasing of services.

d) Case management/evaluation. The activities of the various agencies and/or their contractual agents designed to ensure beneficiaries are receiving scope and amount of services required to optimize their health and independence. The broad range of services includes periodic review of service plans, coordination of services with the beneficiary's acute care management entity (Rhody Health Partners, RIte Care, or Connect Care Choice), and quality assurance. Depending on the agency and the population served, this may be performed by multiple entities working in collaboration or a single entity.

0399.06.01 Initiating the Assessment and Coordination Process

EFF: 07/2009

A screening tool developed by the DHS in collaboration with the health and human services agencies is used to determine the most appropriate placement and/or service

referral for each applicant for LTC. Based on the results of this screen, referrals proceed as follows:

a) Beneficiaries determined to have a potential need for Medicaid funded long-term services and supports in a NF or the community alternative to a NF are referred to the DHS;

b) Beneficiaries determined to have a potential need for State-only funded long-term services and supports, including transportation and the DEA co-pay program, are referred to the DEA;

c) Beneficiaries determined to have a potential need for services for persons with developmental disabilities are referred to the MHRH;

d) Beneficiaries determined to have a potential need for long-term hospital services are referred to MHRH;

e) Beneficiaries determined to have a potential need for behavioral health services for a child or for an adult are referred to the DCYF or MHRH, respectively;

f) Beneficiaries who are not seeking information on long-term care services are referred to the appropriate agency, unit or entity. For example, information on acute managed care options is currently provided by the RI-DHS Enrollment Hotline.

0399.07 LONG-TERM CARE OPTIONS COUNSELING PROGRAM

EFF: 07/2009

A long-term care options counseling program is designed to provide beneficiaries and/or their representatives information concerning the range of options that are available in Rhode Island to address a person's long-term care needs. The options discussed include the institutional care available, the home and community-based care that is available and

how to access these services. The sources and methods of both public and private payment for long-term care services are addressed.

An initial screening to determine how a person would be most appropriately served is conducted. This screening includes a determination of the need for crisis intervention, the available sources of funding for services, and the need for community services, Medicaid, or other publicly funded services.

A person who applies for Medicaid long-term care services shall be provided with a long-term care consultation.

A person admitted to or seeking admission to a long-term care facility regardless of the payment source shall be informed by the facility of the availability of the long-term care options counseling program and shall be provided with a long-term care options consultation if they so request.

0399.08 COST NEUTRALITY FOR HOME AND COMMUNITY-BASED SERVICES
EFF: 07/2009

The DHS is responsible for reviewing and approving the aggregate cost neutrality of the home and community based long-term care system on an annual basis. To meet cost neutrality, the average per capita expenditures for home and community-based services cannot exceed one hundred percent (100%) of the average per capita expenditures of the cost of institutional services if the individuals had been institutionalized
The average monthly costs to Medicaid by institution are:

- Nursing Facilities $ 5,531.00
- ICF-MR $18,758.34
- ESH $24,195.00

The DHS uses these average monthly costs to Medicaid to assist in determining whether home and community-based services are cost effective as required under Title XIX of the Social Security Act.

0399.10 OVERVIEW: DETERMINATIONS OF NF LEVEL OF CARE

EFF: 07/2009

Effective July 1, 2009, the terms and conditions set forth in the Global Consumer Choice Waiver shall apply to all new applicants for Nursing Facility (NF) long-term care (LTC), irrespective of where the beneficiary resides at the time financial and clinical eligibility for services are determined.

The Global Waiver allows NF long-term care services to be provided in an institutional or home and community-based setting depending on the determination of the beneficiary's needs, individual plan of care, and the budget neutrality parameters established under the Global Waiver. Beneficiaries with care needs in the NF category also have an option for self-direction. The service classifications designed to reflect the scope and intensity of the beneficiary's needs in this category are as follows:

a) Highest need. Beneficiaries with needs in this classification have access to all core and preventive services defined in Section 0399.04.02.01 as well as the choice of receiving services in an institutional/nursing facility, home, or community-based setting.
b) High need. Beneficiaries with needs in this classification have been determined to have needs that can safely and effectively be met at home or in the community with significant core and preventive services. Accordingly, these beneficiaries have access to an array of community-based core and preventive services required to meet their needs specified in the individual plan of care.
c) Preventive need. Beneficiaries who do not yet need LTC but are at risk for the NF level of care have access to services targeted at preventing admission, re-admissions or reducing lengths of stay in a skilled nursing facility. Core home and community-based services are not available to beneficiaries with this level of need. Medicaid beneficiaries, eligible under Section 0399.12.03, who meet the preventive need criteria, are not subject to the LTC financial eligibility criteria established in Sections 0380.40-0380.40.35 and 0392.15.20-0392.15.30.

0399.10.01 Agency Responsibilities for Determining Nursing Facility Level of Care Needs

EFF: 07/2009

Beginning on July 1, 2009, beneficiaries determined to have a potential need for Medicaid-funded long-term services and supports in a nursing facility or in the community are referred to the Assessment and Coordination Organization (ACO) processes administered by the Department of Human Services (DHS)**.** Those applying for state-only funded services and supports are referred to ACO processes administered by the Department of Elderly Affairs (DEA). The agency entities authorized to carry out these ACO processes are responsible for:

a) Coordinating related activities with the Medicaid financial eligibility staff;
b) Conducting assessments that determine level of care needs;
c) Developing service plans with the active involvement of beneficiaries and their families;
d) Establishing funding levels associated with care plans developed for each beneficiary;
e) Reviewing service plans on a periodic basis; and
f) Working in collaboration with the beneficiary's care management plan or program (Connect Care Choice; PACE; Rhody Health Partners) to ensure services are coordinated in the most effective and efficient manner possible.

Financial eligibility for Medicaid-funded long-term care is conducted by the DHS field staff in accordance with Sections 0380.40-0380.40.35 and 0392.15.20-0392.15.30. Determinations of clinical level of care needs for nursing facilities are made by the DHS Office of Medical Review (OMR) nurses for both DHS and DEA beneficiaries.

0399.11 CLINICAL ELIGIBILITY ASSESSMENT TOOL

EFF: 07/2009

In determining clinical eligibility, the OMR staff uses an assessment instrument based on the nationally recognized Minimum Data Set (MDS) 2.0 Tool for NF care. To make the

final determination of care needs, the results of this assessment are mapped against the needs-based and institutional level of care criteria. The DHS shall make available to the public the procedural guidelines for use of the assessment as well as the instrument itself.

0399.12 APPLICATION OF NF LEVEL OF CARE CRITERIA

EFF: 07/2009

Upon completing the assessment, the OMR staff determines whether a beneficiary's care needs qualify as highest, high or preventive based on a set of criteria that reflect both best practices across the states and the standards of prevailing care within the LTC community in Rhode Island. Clinical eligibility based on these criteria is set forth in the following Sections.

0399.12.01 Highest Need

EFF: 07/2009

Beneficiaries shall be deemed to have highest level of care need when they:

a) Require extensive assistance or total dependence with at least one of the following Activities of Daily Living (ADL) -- toilet use, bed mobility, eating, or transferring AND require at least limited assistance with any other ADL; or

b) Lack awareness of needs or have moderate impairment with decision-making skills AND have one of the following symptoms /conditions, which occurs frequently and is not easily altered: wandering, verbally aggressive behavior, resists care, physically aggressive behavior, or behavioral symptoms requiring extensive supervision; or

c) Have at least one of the following conditions or treatments that require skilled nursing assessment, monitoring, and care on a daily basis: Stage 3 or 4 skin ulcers, ventilator, respirator, IV medications, naso-gastric tube feeding, end stage disease, parenteral feedings, 2nd or 3rd degree burns, suctioning, or gait evaluation and training; or

d) Have one or more unstable medical, behavioral or psychiatric conditions or chronic or reoccurring conditions requiring skilled nursing assessment, monitoring and care on a daily basis related to, but not limited to, at least one of the following: dehydration, internal bleeding, aphasia, transfusions, vomiting, wound care, quadriplegia, aspirations, chemotherapy, oxygen, septicemia, pneumonia, cerebral palsy, dialysis, respiratory therapy, multiple sclerosis, open lesions, tracheotomy, radiation therapy, gastric tube feeding, behavioral or psychiatric conditions that prevent recovery.

0399.12.01.01 Exceptions -- Highest Need

EFF: 07/2009

Beneficiaries who do not meet the criteria to establish highest need as indicated in the previous Section maybe deemed clinically eligible for this level of care if the OMR determines that the beneficiary has a critical need for long-term care services due to special circumstances that, if excluded from this level of care, may adversely affect the beneficiary's health and safety. These special circumstances include but are not limited to:

1. Loss of primary caregiver (e.g. hospitalization of spouse, death of spouse);
2. Loss of living situation (e.g. fire, flood);
3. The individual's health and welfare shall be at imminent risk if services are not provided or if services are discontinued (e.g. circumstances such as natural catastrophe, effects of abuse or neglect, etc.); or
4. The individual's health condition would be at imminent risk or worsen if services are not provided or if services are discontinued (e.g. circumstances such as natural catastrophe, effects of abuse or neglect, etc.)

0399.12.02 High Need

EFF: 07/2009

Beneficiaries shall be deemed to have the high level of care need when they:

a) Require at least limited assistance on a daily basis with at least two of the following ADL's: bathing/personal hygiene, dressing, eating, toilet use, walking or transferring; or

b) Require skilled teaching or rehabilitation on a daily basis to regain functional ability in at least one of the following: gait training, speech, range of motion, bowel or bladder control; or

c) Have impaired decision-making skills requiring constant or frequent direction to perform at least one of the following: bathing, dressing, eating, toilet use, transferring or personal hygiene; or

d) Exhibit a need for a structured therapeutic environment, supportive interventions and/or medical management to maintain health and safety.

0399.12.03 Preventive Need
EFF: 07/2009

Beneficiaries who meet the preventive need criteria shall be eligible for a limited range of home and community-based services and supports along with the health care they are entitled to receive as recipients of Medicaid. Preventive care services optimize and promote beneficiary health, safety and independence through an array of care interventions that alleviate or minimize symptoms and functional limitations. Accordingly, the goal of preventive services is to delay or avert institutionalization or more extensive and intensive home and community-based care.

To qualify, the OMR must determine that one or more preventive services will improve or maintain the ability of a beneficiary to perform ADL's or IADL's and/or delay or mitigate the need for intensive home and community-based or institutionally based care. Preventive services for beneficiaries include:

a) Homemaker Services- General household tasks including basic home and household assistance for a health condition or to address functional limitations. The services include meal preparation, essential shopping, laundry and cleaning for beneficiaries without social support systems able to perform services for them.

b) Minor Environmental Modifications: Minor modifications to the home may include grab bars, versa frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats and other simple devises or appliances such as eating utensils, transfer bath bench, shower chair, aids for personal care (e.g. reachers) and standing poles to improve home accessibility adaptation, health or safety.

c) Physical Therapy Evaluation and Services: Physical therapy evaluation for home accessibility appliances or devices by an individual with a state-approved licensing or certification. Preventive physical therapy services are available prior to surgery if evidence-based practice has demonstrated that the therapy will enhance recovery or reduce rehabilitation time.

d) Respite Services- Temporary care giving services provided to an individual unable to care for him/herself because of the absence or need for relief of those persons normally providing the care. Respite services can be provided in the individual's home or in a facility approved by the state, such as a hospital, nursing facility, adult day services center, foster home or community residential facility. An individual qualifies for these respite services if he/she requires the services of a professional or qualified technical health professional or requires assistance with at least two activities of daily living.

0399.12.03.01 Limitations -- Preventive Need

EFF: 07/2009

Access to and the scope of preventive services for qualified beneficiaries may be limited depending on the availability of funding. The DHS may establish wait lists, in

accordance with the provisions established in Section 0399.14, if such limitations become a necessity.

0399.13 REASSESSMENTS—HIGH AND HIGHEST NEED

EFF: 07/2009

Change in Needs – High and Highest. Beneficiaries determined to have high need at the time of a reassessment, or in the event of a change in health status, shall be determined to have the highest need if they meet any of the clinical eligibility criteria established for that level of care in section 0399.21.01.

0399.13.01 Timely Re-Evaluation of Beneficiaries with the Highest Need

EFF: 07/2009

At the time the OMR makes a determination of highest need for a beneficiary who resides in or is admitted to a nursing facility, information indicating whether there is a possibility that the beneficiary's functional or health care condition may improve, within a two month period is identified. The OMR notifies the beneficiary, his/her authorized representative and the nursing facility that NF level of care has been authorized and that the beneficiary's functional and medical status will be reviewed in thirty (30) to sixty (60) days. At the time of the review, the OMR confirms that the beneficiary is still a resident of the nursing facility. Once this determination is made, the OMR reviews the most recent Minimum Data Set and requests any additional information necessary to make one of the following determinations:

a) The beneficiary no longer meets the criteria for highest level of need. In this instance, the beneficiary, and/or his/her authorized representative, and the nursing facility are sent a discontinuance notice by the Long Term Care Unit. Prior to being sent a discontinuance notice, the beneficiary will be evaluated to determine whether or not the criteria for high need have been met. Payment for care provided to a beneficiary determined to no longer have the highest need shall continue until the DHS has completed the transition to a more appropriate setting.

b) The beneficiary continues to meet the appropriate level of care, and no action is required.

3. Beneficiaries residing in the community who are in the Highest and High groups will have, at a minimum, an annual assessment.

0399.14 LIMITATIONS ON THE AVAILABILITY OF SERVICES

EFF: 07/2009

Should the demand for home and community-based long-term care services exceed supply or appropriations, beneficiaries with the highest need shall have the option of seeking admission to a nursing facility while awaiting access to the full scope of home and community-based services. Specifically, beneficiaries and applicants in the highest category are entitled to services and shall not be placed on a waiting list for institutional services. If a community placement is not initially available, they may be placed on a wait list for transition to the community.

In the event that a waiting list for any home and community-based service becomes necessary for any reason, the DHS must provide services for beneficiaries determined to be highest need before providing services to beneficiaries that have a high need or preventive need. Beneficiaries with high need are given priority access to services over beneficiaries qualifying for preventive services.

Additionally, beneficiaries receiving services must continue to have access to and receive such services unless their condition improves and they no longer meet the same clinical eligibility criteria.

0399.15 LIMITATION -- APPLICABILITY OF GLOBAL WAIVER LEVEL OF CARE CRITERIA

EFF: 07/2009

For those beneficiaries residing in an institution prior to July 1, 2009, the DHS must apply the level of care criteria in effect at the time those beneficiaries were initially determined unless the participant transitions to the community because he or she (a) improves to a level where they would no longer meet the pre-demonstration institutional level or care, or (b) the individual chooses community care over institutional care. Once that beneficiary is residing in the community, all future redeterminations of need will be based on the criteria for determining clinical eligibility established in this rule for the purposes of implementation of the Global Consumer Choice Compact Waiver.

0399.20 OVERVIEW: LONG-TERM CARE RESIDENTIAL SERVICE SETTINGS OPTIONS

EFF: 07/2009

There are several community-based service options in residential settings, other than the home and nursing facilities, which may be available to beneficiaries who are determined under Sections 0399.12.01 and 0399.12.02 to have a need for the highest or high level of care. Beneficiaries will be notified of whether they qualify for one of these residential options in conjunction with the comprehensive assessment specified in Sections 0399.05.01.02 and 0399.11 and the development of the individualized plan of care. Although Medicaid coverage for room and board is typically not included for these options, there are exceptions as is explained in the description of services provided below.

0399.20.01 Assisted Living

EFF: 07/2009

Assisted living services are available to qualified long-term care (LTC) beneficiaries who have been determined to have a highest or high level of care need that can be safely and effectively met in a state licensed assisted living residence that has also been certified as a Medicaid provider. The responsibility for certifying licensed assisted living residences

as Medicaid providers is shared by the Executive Office of Health and Human Services, the Department of Human Services or the Department of Elderly Affairs. Certification standards adopted by these agencies in effect on June 30, 2009 shall remain in effect under the Global Consumer Compact Waiver until October 1, 2009, by which time the office and the departments shall develop and implement new certification standards that broaden the scope and availability of assisted living services to the full extent permitted by state law and appropriations.

For the purpose of this rule, assisted living services are defined as: personal care services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under state law), transportation to medically necessary appointments, therapeutic social and recreational programming, when specified, provided in a home-like environment in a licensed community care facility in conjunction with residing in the facility. The services provided to beneficiaries by assisted living residences certified as Medicaid providers for the purposes of R.I.G.L. § 42.66.8-3 must also include those set forth in section 0300.20.20. Beneficiaries opting for services in the assisted living residences covered under this section of state law may be subject to waiting lists as the number of beds certified for Medicaid purposes is capped. Such beneficiaries shall have the option of seeking assisted living services in other Medicaid certified residences, depending on the scope of their needs as indicated in the individualized plan of care.

0399.20.02 Shared Living

EFF: 07/2009

Shared Living is defined as personal care, homemaker, chore, attendant care and related services provided in a private home setting by a care provider who lives in the home. Shared Living is a service provided to Medicaid beneficiaries eligible for long-term care services who are elderly or adults with disabilities who are unable to live independently and who meet the highest or high level of care as determined through the evaluation conducted by the Assessment and Coordination Organization as specified in Section

0399.06. Each Medicaid beneficiary opting for shared living services will have a Shared Living Service and Safety Plan, developed to meet their own unique, individual needs.

Shared living providers certified to serve Medicaid beneficiaries shall be selected in accordance with the standards developed for such purposes under the auspices of the Executive Office of Health and Human Services. These certification standards vary by population served so as to ensure services can be tailored to better meet the needs of beneficiaries.

0399.20.02.01 Scope and Limitations

EFF: 07/2009

Shared living certification standards and options developed and implemented by the Department of Mental Health, Retardation and Hospitals (MHRH) in effect on June 30, 2009 shall remain in effect under the Global Waiver unless or until such time as the MHRH determines otherwise.

0399.21 PROGRAM FOR ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

EFF: 07/2009

The Program for All-Inclusive Care for the Elderly (PACE) is a Medical Assistance program administered by the DHS that provides an integrated model of medical and long-term care services to qualified persons age fifty-five (55) and above. To qualify as a Medicaid eligible PACE participant, an individual must:

- Meet the Medical Assistance requirement for disability and be at least fifty-five (55) years of age, or meet the Medical Assistance requirement for age (65 or older);

- Meet the highest or high level of care;

- Meet all other financial and non-financial requirements for Medical Assistance long-term care services, such as, but not limited to, citizenship, residency, resources, income, and transfer of assets.

CMS and the Center for Adult Health approved PACE providers are responsible for providing the full scope of Medicaid State Plan categorical and medically needy services and the following additional services:

- Multidisciplinary assessment and treatment planning;
- Case Management services;
- Personal Care;
- Homemaking;
- Rehabilitation;
- Social Work;
- Transportation;
- Nutritional Counseling;
- Recreational Therapy;
- Minor Home Modifications;
- Specialized Medical Equipment and Supplies.

The PACE program is voluntary for any eligible person, but if an individual selects this program, he/she must get all medical and support services through the PACE organization. There are no benefits outside of the PACE program.

DHS long term care/adult services staff is responsible for:

- All determinations and redeterminations of Medicaid Long Term Care categorical or medically needy eligibility and post-eligibility as described in Sections 0396.10 through 0396.10.20, and Sections 0396.15 through 0396.15.10.10;

- Determination of income to be allocated to cost of care (share);

- Maintenance of the DHS InRhodes and paper case file;

- Assisting disenrolled clients in application for alternate Medicaid Long Term Care programs, as needed.

The approved PACE provider is responsible for:

- Point of entry identification;

- Submitting all necessary documentation for level of care initial determinations and redeterminations and referral to DHS long term care/adult services offices for financial determinations;

- Checking Medicaid eligibility status and required share amount (if any) prior to enrolling the client in PACE as a Medicaid eligible individual, and at each reassessment;

- Providing and coordinating all needed services;

- Adhering to all PACE Provider requirements as outlined in the PACE Program Agreement between DHS and CMS, and to all credentialing standards required by the DHS Center for Adult Health including data submission.

The DHS Center for Adult Health is responsible for:

- Oversight and monitoring of all aspects of the PACE program;

- Conducting initial Level of Care Determinations and determining whether a permanent Level of Care should be assigned;

- o Identifying clients for whom there is unlikely to be an improvement in functional/medical status.

0399.21.01 Involuntary Disenrollment

EFF: 07/2009

The PACE Organization may not request disenrollment because of a change in the enrollee's health status or because the enrollee's utilization of medical and/or social services, diminished mental capacity or uncooperative behavior is resulting from his or her special needs (except as specified below). Involuntary disenrollment conditions described in 42 CFR Section 460.164 will be used in Rhode Island. A person may be disenrolled for any of the following reasons:

o Non-payment of premiums on a timely basis: failure to pay or make satisfactory arrangements to pay any premium or co-payment due the PACE organization after a 30 day grace period.

o The participant moves out of the PACE program service area or is out of the service area for more than thirty (30) days unless the PACE organization agrees to a longer absence due to extenuating circumstances.

o The PACE organization is unable to offer health care services due to the loss of State licenses.

o The PACE organization's agreement with CMS and the State-administering agency is not renewed or terminated.

o The participant is defined as a person who engages in disruptive or threatening behavior, including times when the participant physically attacked, verbally threatened, or exhibited harassing behavior toward a PACE program staff member, contractor, or other PACE program participant.

o A person whose behavior is jeopardizing his/her health or safety or that of others.

o A person with decision-making capacity who consistently refuses to comply with his/her individual plan of care or the terms of the Enrollment Agreement.

o A participant may lose eligibility for the PACE program and be disenrolled because they no longer meet level of care requirements.

0399.21.02 Department Approval for Involuntary Disenrollment
EFF: 07/2009

Involuntary disenrollment from PACE requires the DHS Center for Adult Health approval. A proposed involuntary disenrollment for any of the above reasons shall be subject to timely review and prior authorization by the Department, pursuant to the Involuntary Disenrollment procedure below:

o Disenrollment request: The PACE Organization (PO) shall submit to the DHS Center for Adult Health a written request to process all involuntary disenrollments. With each request, the PACE Organization shall submit to DHS evidence attesting to the above situations.

o Department's Approval: The Department will notify the PACE Organization about its decision to approve or disapprove the involuntary disenrollment request within fifteen (15) days from the date DHS has received all information needed for a decision.

o Upon DHS approval of the disenrollment request, the PACE Organization must, within three (3) business days, forward copies of a completed Disenrollment Request Form to the DHS Long Term Care Office and to the Medicare enrollment agency (when appropriate).

0399.21.03 Notification to the Member

EFF: 07/2009

If and when the DHS approves the PACE Organization's request for disenrollment, the PACE Organization must send written notification to the member that includes:

o A statement that the PACE Organization intends to disenroll the member;
o The reason(s) for the intended disenrollment; and
o A statement about the member's right to challenge the decision to disenroll and how to grieve or appeal such decision.

0399.21.04 Disenrollment Appeal

EFF: 07/2009

If the member files a written appeal of the disenrollment within ten (10) days of the decision to disenroll, the disenrollment shall be delayed until the appeal is resolved.

0399.21.05 Loss of PACE Enrollment

EFF: 07/2009

When a member loses PACE enrollment, the effective dates of disenrollment from the PACE Organization will be determined as follows:

o Loss of Functional Level of Care: No longer requires the level of care provided in a nursing facility as defined in section 0399.12.01.

o Out of Area Residence: The PACE Organization will notify the appropriate agencies, Medicare and/or Medicaid, if the member moves permanently out of the designated PACE catchment area. If the member moves permanently out of the catchment area, the date of disenrollment for Medicaid shall be the date when the move

occurs. DHS will recoup Medicaid capitation payments made for any months after the month an out of area move occurs.

o Death: If the participant dies, the date of disenrollment shall be the date of death. DHS will recoup any whole capitation payments for months subsequent to the month a participant dies.

0399.21.06 Notification to the Participant

EFF: 07/2009

When the PACE Organization notifies the Center for Adult Health and Medicare enrollment agencies of the loss of PACE enrollment, the PACE Organization shall also send written notification to the member. This written notification shall include:

o A statement that the participant is no longer enrolled in the PACE program;

o The reason(s) for the loss of PACE enrollment.

0399.21.07 Re-enrollment and Transition Out of PACE

EFF: 07/2009

o All re-enrollments will be treated as new enrollees except when a participant re-enrolls within two months after losing Medicaid eligibility. In this situation, the participant's re-enrollment will not be treated as a new enrollment. The PACE Organization shall assist participants whose enrollment ceased for any reason in obtaining necessary transitional care through appropriate referrals, by making medical records available to the participant's new service providers; and (if applicable), by working with DHS to reinstate participant's benefits in the Medical Assistance Program.

0399.21.08 Voluntary Disenrollment

EFF: 07/2009

Participants in the PACE Program may voluntarily disenroll from the PACE Organization at any time. A voluntary disenrollment from the PACE Organization will become effective at midnight of the last day of the month in which the disenrollment is requested.